Long Term Care Highlights

November 2002

North Dakota Department of Health
Division of Health Facilities

Pain Management in Long Term Care

Presented by Steven Levenson, MD, CMD, sponsored by
North Dakota Health Care Review, Inc., October 2001
By Linda Maher, RN, Health Facilities Surveyor

Inside this issue:

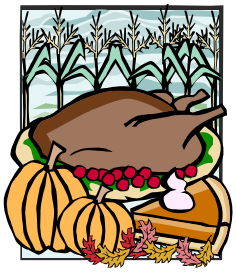
Special points of interest:

- Ensuring commitment to resident comfort (pain management)
- Variety of meals and snacks for residents
- Importance of vitamins in the residents' diet
- Water as a nutrient

Chronic pain is common in the long term care setting and is generally under-recognized and under-treated.

The following are common misconceptions relating to chronic pain in the elderly:

•It is a sign of personal weakness to acknowledge chronic pain.
•To bear pain without complaint denotes strength of character.
•It is an inevitable part of aging and nothing can be done about it.
•It is a punishment for past actions.
•It always indicates the presence of a serious disease.
•Acknowledging pain will mean undergoing intrusive and possibly painful tests.
•Elderly, especially cognitively impaired, have a higher tolerance for pain.
•Elderly and cognitively impaired cannot be accurately assessed for pain.
•Long term care residents say they are in pain in order to get attention.



•Elderly residents are likely to become addicted to pain medications.

Chronic pain often is associated with depression in the long term care resident. Some residents diagnosed with mood or thought disorders and treated with psychotropic medication actually have unrecognized and untreated pain.

Since almost all long term care residents have predisposing factors for the development of chronic pain, pain assessments should be regular and systematic.

Assess residents for pain:
•Upon admission to a long term care facility.
•At each quarterly review.
•Whenever change in condition prompts completion of the MDS.
•At any time pain is suspected.

Observe residents for these nonspecific signs and symptoms that may suggest pain:

- Frowning, grimacing, fearful facial expression, grinding of teeth.
- Bracing, guarding, rubbing.
- Fidgeting, increasing or recurring restlessness.
- Striking out, increasing or recurring agitation.
- Eating or sleeping poorly.
- Sighing, groaning, crying, breathing heavily.
- Decreasing activity levels.
- Resisting certain movements during care.
- Change in gait or behavior.
- Loss of function.

Pain Management in Long Term Care (cont.)

The following are possible indicators of chronic pain in MDS – version 2.0:

- Sleep cycle (E1)
- Sad, apathetic, anxious appearance (E1)
- Change in mood (E3)
- Resisting care (E4)
- Change in behavior (E5)
- Loss of sense of initiative or involvement (F1)
- Functional limitation in range of motion (G4)
- Change in ADL function (G9)

Even if you are on the right track, you'll get run over if you just sit there.

The following are principles in treatment of pain in long term care:

- Environment should be as comforting and supportive as possible.
- Back rub, whirlpool bath, or shower as indicated.
- Reassuring words and touch. Topical analgesic or a mild oral analgesic.
- Opportunity to talk to caregivers and others about chronic pain, its causes and consequences, and plan for treating the pain.
- Services of chaplain or other appropriate pastoral counselor.
- General comfort measures may reduce need for high analgesic doses.

Nursing assistants and other direct care-giving staff play a crucial role in providing comfort measures.

An interdisciplinary team approach is imperative in developing an individualized care plan for the resident. Certain events or activities may exacerbate the resident's pain. Medication may be more effective if given before activities so it is important to individualize the administration of medications to meet the resident's needs. Documentation of all pain relief measures should be made in the resident's medical record. If the resident or family refuses pain relief measures that are offered, this fact should also be documented in the medical record along with the reasons for the refusal.

Pain medication should be administered routinely and not used PRN unless pain is intermittent and relieved by PRN or as needed medication. The elderly are more likely to experience adverse reactions to medications. It is important to begin with a low dose and titrate carefully until comfort is achieved, and to reassess and adjust the dose frequently to optimize pain relief while monitoring and managing side effects.

Managers of long term care facilities must ensure commitment to resident comfort. To manage pain means to make a commitment to the resident to use a variety of strategies to soothe distressing symptoms so that the overall quality of life of the resident is improved. Education about pain assessment and treatment is an essential part of training and orientation programs in long term care facilities.

Quality Improvement Organization Initiatives

By Darleen Bartz, Chief, Health Resources Section

Darleen Bartz presented the following information at a press conference in Fargo, Nov. 12, 2002.

I am pleased to be here today to provide the Department of Health's support for the new Centers for Medicare & Medicare Services Quality Improvement Organization initiatives. The goal is to help families make informed choices in care for their loved ones.

The information released today identifies the numbers of residents with specific care needs in each facility. If you have a loved one with such needs, this information would be one source we recommend that you refer to when considering nursing home placement.

This initiative also will provide facilities with the tools to continually work towards improvement of the quality care and services for their residents. These efforts compliment the quality assurance activity carried out by the state survey agency within the Department of Health. We believe these measures will provide new and needed opportunities for facilities to receive consultation and education that will result in increased quality care for the residents in our state.

Our goal is to help ensure that residents of nursing homes receive the best care possible. We are pleased to partner with the Quality Improvement Organization on this initiative and support them as they move forward with these activities. Thank you.

Nutrition for the Elderly Adult

By Cheri Grabanski, LRD, Health Facilities Surveyor

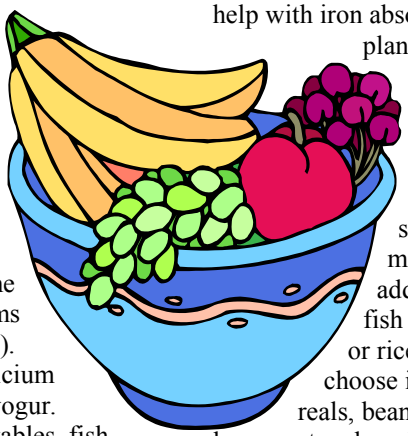
Too often, variety is lacking in meals or snacks the elderly consume, putting the elderly at risk for many health risks secondary to a nutrient-poor diet. There are various reasons why older adults may not be eating the most nutrient rich meals, which is all the more reason for health professionals and care providers to be aware of the importance of food.

As we age, we continue to need the same nutrients (protein, carbohydrates, fat, vitamins, minerals and water) as we did when we were in our youth, only in different amounts. For some individuals, getting enough nutrients may be the challenge. The elderly tend to decrease the amount of food they eat for various reasons, making it harder to achieve optimal nutritional status.

Calorie needs change due to more body fat and less lean muscle. Less activity can further decrease the amount of calories needed. Although calorie needs vary depending on activity level, age, weight, height and gender, many older adults need about 1,600 to 2,000 calories daily. Chosen carefully, those 1,600 to 2,000 calories can be nutrient packed and can supply the minimum recommendations from the Food Guide Pyramid (1). The following daily servings add up to about 1,600 calories:
bread group – six servings;
vegetable group – three servings;
fruit group – two servings;
dairy group – two servings;
meat group – two servings; and
fats/oils group – use sparingly (1).

Protein requirements can vary because of chronic disease. Older adults need at least five ounces, or two to three servings of protein a day (1). This will help maintain adequate muscle mass, fight infection and maintain strength during trauma. However, protein-rich foods such as meat and poultry may be hard to chew for some. The following are some tips for adding protein in meals or snacks: choose tender cuts of meat such as chicken, turkey or ground meat; use meat, fish and poultry in casseroles; have the individual's teeth, gums and/or dentures checked regularly if chewing is a problem. Include dairy products such as milk, cheese and yogurt, which also supply protein as well as calcium; offer eggs (which are well cooked to prevent food borne illness), beans and peanut butter; and make gravies and sauces with low-fat milk or add dry skim milk powder to soups, casseroles and creamed dishes.

To help maintain bone mass and reduce the risk/further progression of osteoporosis, calcium recommendations increase for the elderly. Both men and women older than 50 should consume at least 1,200 milligrams of calcium each day (1). The best sources of calcium are milk, cheese, and yogur. Dark green leafy vegetables, fish with edible bones, tofu made with calcium sulfate and calcium-fortified fruit juices and cereals also contain calcium.



Vitamin D and calcium are partners to one another. Vitamin D helps deposit calcium into the bones and helps protect against bone disease by keeping the bones stronger. Sunshine, which in North Dakota is scarce at times, is an important factor in maintaining appropriate vitamin D status in the elderly. The normal adult is believed to obtain sufficient vitamin D from exposure to sunlight and the ingestion of small amounts in foods. However, for those individuals who are not exposed to adequate sunlight it is important to provide vitamin D-fortified milk and cereals at meals and/or snacks.

Iron deficiency may become a problem in the elderly and often leads to anemia and its symptoms of fatigue, weakness and poor health (1). To enhance iron absorption, consume vitamin C with iron-rich foods. This helps with the body's ability to absorb the iron. The vitamin C will help with iron absorption from both plant and animal sources. The following are some ways to consume iron: serve vitamin C-rich sources of juice at meals or snacks; add meat, poultry, fish or beans to pasta or rice dishes; and choose iron-enriched cereals, beans, whole-grains, lean meat and poultry.

Nutrition for the Elderly Adult (cont.)

Vitamin A found in dark green leafy and yellow and orange vegetables is essential for vision, maintenance of skin and other body tissues.

Folate found in leafy, green vegetables, oranges/orange juice, beans, enriched grain and some fortified cereals helps the body make red blood cells. Low folate intake can lead to anemia. (1)

Vitamin B12 works along with folate to make red blood cells. Too little vitamin B12 also can lead to anemia and, in some older adults, is linked to neurological problems (1). Good sources include meat, poultry, fish, eggs and dairy foods.

Pernicious anemia, a vitamin B12 deficiency, is caused by the inability to absorb vitamin B12. Dietary sources of vitamin B12 are ineffective for treating pernicious anemia. In these cases, vitamin B12 must be injected.

Zinc helps fight infections and repairs body tissue. Good sources include meat, seafood, whole-grains and milk.

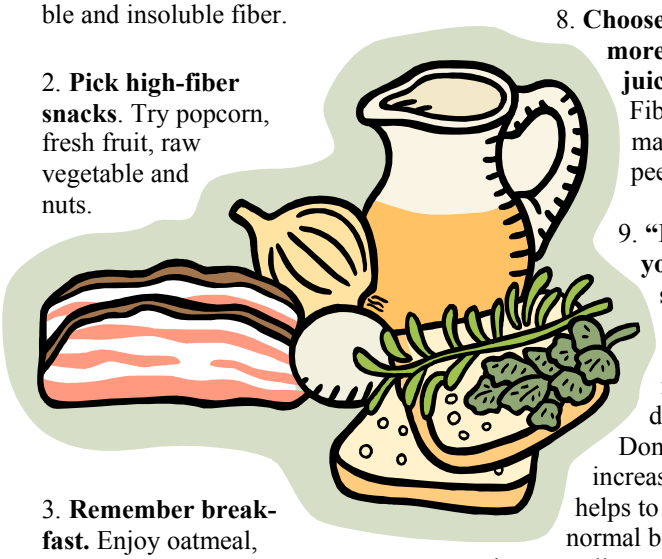
Of all the nutrients, water is the most important and generally receives little attention as a nutrient. Water serves many essential functions. On average, an adult's body weight is made of about 10 to 12 gallons of water (about 55 percent to 75 percent of body weight).

When exposed to extremely high temperatures, your body requires even more water to maintain its normal temperature (2). The average adult loses about 2 ½ quarts (about 10 cups) of water daily through perspiration, breathing and other body functions (2). Older adults need about 8 to 12 cups of fluid per day. This level of fluid intake also can ease constipation.

Adequate fiber, 20 to 35 grams of fiber-rich foods daily, together with adequate fluid intake, also helps maintain normal bowel function. Here are nine ways to "fiber up."

1. **Eat a variety of food**. With a mix of foods, you consume a mix of both soluble and insoluble fiber.

2. **Pick high-fiber snacks**. Try popcorn, fresh fruit, raw vegetable and nuts.



3. **Remember breakfast.** Enjoy oatmeal, whole-bran muffins or whole-wheat waffles. Check food labels for a cereal with five or more grams of fiber per serving. Top with fruit for a little more fiber.

4. **Try whole-grains,** in bread, cereals, buns, bagels and pasta. Breads with whole grain include cornbread from whole, ground cornmeal; cracked wheat bread; oatmeal bread; pumpernickel bread; rye bread and whole-wheat bread.

5. **Eat legumes two to three times a week.**

6. **Eat at least five servings of fruits and vegetables daily.**

7. **Enjoy fruit and vegetables with the edible skin on.** With the skin a medium potato has 3.6 grams of fiber. Skinless, it has less, about 2.3 grams.

8. **Choose whole fruit more often than juice.** Fiber is found mainly in the peel and pulp.

9. **"Fiberize" your cooking style.** Add bran to meatballs or meatloaf dishes (3).

Don't forget that increasing activity helps to maintain normal bowel function as well as adequate fluid and fiber intake.

Nutrition for the Elderly Adult (cont.)

So stay "energized" with a variety of foods and keep hydrated no matter what the weather because thirst is not the only indication of one needing water. Help keep normal bowel functioning by eating five a day and including some activity into one's day. Also, keep in mind that food not only has physical importance but emotional importance as well. The pleasurable experience in food and eating can contribute notably to a person's quality of life and nutritional status.

1. Nutrition for older adults. American Dietetic Association. www. eatright.com.

2. Ten Great Ways to "Fiber Up!" American Dietetic Association. www. eatright.com.

3. Summer Heat Waves Can Cause Risk for Dehydration. American Dietetic Association. www. eatright. com.

The smallest deed done is greater than the best of intentions.

RAI Training

By Patricia Rotenberger
State RAI Coordinator

The Centers for Medicare & Medicaid Services (CMS) has not completed the revised Long Term Care Resident Assessment Instrument (RAI) User's manual. The prevailing comment from providers and state RAI coordinators was to remove the swing bed MDS information from the users manual. CMS has decided to do that, causing a delay in the publication of the revised manual.

Due to this delay and difficulty with scheduling a room at the State Capitol, a Basic RAI workshop was held Nov. 6 & 7, 2002. A spring Basic RAI workshop will be scheduled as soon as the final revised RAI User's Manual is published.

If you have any questions about this information or any MDS questions, please contact Pat Rotenberger, state RAI coordinator, at 701.328.2352 or protenbe@state.nd.us

Questions Regarding Med Pass During Survey

By Bruce Pritschet, Director,, Health Facilities

Recently, questions have been forwarded to our survey agency relating to the medication pass conducted by the survey team during a long term care survey. The question, as received, indicated there is confusion about how the medication pass is to be conducted. The complete instructions for "med pass observation" appear in the guidance to surveyor in appendix pp in the state operations manual starting on page 135.4 and continuing for several pages.

If you would like to view the appendix pp on the web, the URL below should take you to the first page of the appendix. Proceed to page 135.4 of the State Operations Manual or page 243 of the pdf file provided.

<http://cms.hhs.gov/manuals/pub07pdf/AP-P-PP.pdf>

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MDS Coding Clarifications

By Patricia Rotenberger
State RAI Coordinator

The Centers for Medicare & Medicaid Services has published quality measures in the newspaper and on its website for consumer review. Some common coding errors are:

- Facilities continue to code a chair that prevents rising as a restraint for a totally dependent resident who cannot move. Be sure to compare the definition of restraints with the effect the restraint has on the resident.

- Facilities are coding a resident as having pain when that resident is on routine pain medications. Determine if the resident has breakthrough pain. If the routine doses of pain medication are controlling the pain, you cannot code the resident as having pain.

- Another area of confusion is the difference in coding from extensive to total ADL support provided by the CNAs. For a resident to have a code of totally dependent for ADLs, the resident must have been totally dependent each time the activity occurred. As soon as the resident did some part of the activity, the resident was not totally dependent.